

☐ Department of Labor & Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291



REQUEST FOR CLAIM INFORMATION

(To be completed by worker, worker's representative
employer, or employer's representative)

☐ Department of Labor & Industries
Self-Insurance
PO Box 44892
Olympia WA 98504-4892

This form must be completed in full

Claim No.

Worker's name

Name of person making request

☐ Worker

☐ Other

Date

Phone

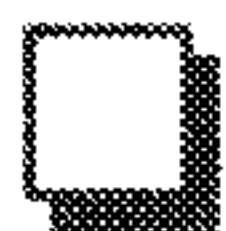
Address

City

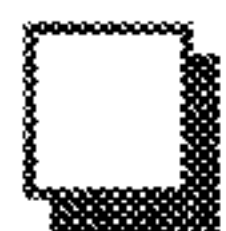
State ZIP

Copies of documents are a chargeable item

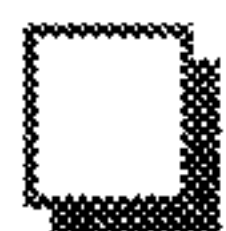
Please check the proper box(s).



I am requesting my claim file.



I am requesting the following information from my claim file:
(for example, "the panel exam of Feb 4, 1977," etc.) Please list below.



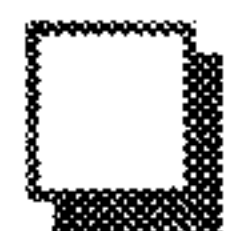
I am the worker's authorized representative requesting the claim file for the worker named above.
I understand that the file contains confidential information and by accepting the file, I accept full
responsibility for any use made of this information. AUTHORIZATION IS:



ON FILE



ATTACHED



I am the employer or employer's representative requesting the claim file for the worker named above.
I understand that the file contains confidential information and by accepting the file, I accept full
responsibility for any use made of this information.

Signature

For Department use only:

Action taken on request

Date action taken

Name of person taking the action

Section/office